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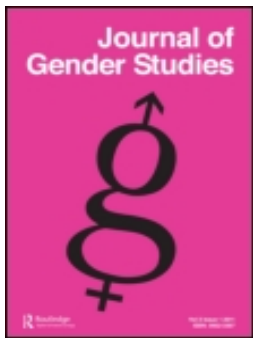
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## RESEARCH ARTICLE

### ‘Can’t cook, won’t cook’: men’s involvement in cooking when their wives develop dementia

Geraldine Boyle\*

*Centre for Applied Social Research, University of Bradford, Ashfield Building,  
Bradford BD7 1DP, West Yorkshire, UK*

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The division of household labour in heterosexual couples continues to be unequal, indicating that gender inequality persists in the domestic sphere. Yet, although there is a lack of gender equity in housework, this is less clear-cut in terms of cooking. This paper explores whether men are willing to cook when their wives develop dementia. The paper presents findings from a qualitative study in England (funded by the Economic and Social Research Council (ESRC)), which explored the everyday decisions made by married couples when one partner had dementia. The author examines the division of labour within the couples and identifies whether women exercised choice and control over who did the cooking. Although research into dementia usually focuses on the social competence of people with dementia (as determined by their carers), this study explored the domestic competence of both spouses, particularly husbands who were carers. It was found that men are often unable or unwilling to cook when their wives develop dementia or, alternatively, they take over cooking altogether, thereby excluding their wives from a task they enjoy. Gendered patterns of authority or control were apparent in the couples’ decision-making dynamics, indicating that gender inequality in relationships persists even when women develop dementia.

**Keywords:** domestic labour; inequality; agency; capacity; dementia

## Introduction

### *The gendered division of household labour*

Research to date has shown that progress towards gender equality in (heterosexual) couples has been slow, despite Giddens’ (1992) prediction of the emergence of egalitarian relationships (see also Arber and Ginn 1995, Sullivan 2006, van Hooff 2011). Gender inequity is especially evident in the unequal division of household labour, as women continue to do most of the housework (Sullivan 2000, Voicu *et al.* 2009, van Hooff 2011). Whilst changes in the employment patterns of women have resulted in some variation in the distribution of housework – notably in dual-earner couples – this has been limited (Speakman and Marchington 1999, Sullivan 2000, van Hooff 2011). Fundamentally, men construct housework as ‘women’s work’ and therefore undertaking it is seen as a threat to their masculine identity (Speakman and Marchington 1999).

Correspondingly, theory on care work more generally (informal or paid care) suggests that such work (whether domestic labour, child care or support given to disabled and older

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\*Email: [g.m.boyle@bradford.ac.uk](mailto:g.m.boyle@bradford.ac.uk)

people) is inherently devalued, both culturally and economically, because of its association with women (see England 2005). In turn, although men's work is seen as deserving of citizenship rights (Glenn 2000), women's involvement in caring (particularly in the private sphere) has been neglected or even disregarded, with the result that their citizenship rights have not received the same state recognition (Abraham *et al.* 2010). Yet, whilst some feminists have called for the inclusion of care as a basis for gendered citizenship (for example, Knijn and Kremer 1997), others have cautioned that identifying care as primarily women's responsibility perpetuates this gendered division of labour (see Pateman 1992, Lister 1999).

Although quantitative research has measured gendered contributions to housework, qualitative studies have explored whether gender role ideologies influence the division of labour (Baxter 2000). In particular, research into male manufacturing workers' attitudes to housework found that, despite working in technical occupations, the men often feigned a lack of expertise or even incompetence in relation to using domestic technology in order to avoid housework (Speakman and Marchington 1999). Likewise, a study of dual-career couples found that men adopt strategies of a lack of competency or inability to achieve adequate standards to justify their failure to take on an equal share of the housework. Indeed, the traditional male-breadwinner ideology continues to influence this gender division, as men's careers still take precedence even when both partners work full-time in professional occupations (van Hooff 2011).

### *The division of housework when women become disabled*

Previous research has given little consideration to the impact of women's disability on men's contribution to household tasks. However, a longitudinal study in the USA found that men's involvement in housework increased (by 8%) after their wives became physically disabled, but only when they became *highly* disabled (and the women still undertook the majority of this work, despite their disability) (Allen and Webster 2001). The same authors concluded that the men's increased involvement in housework reflected a caring response to their partners' need for disability support, rather than being indicative of egalitarian attitudes towards gender roles. Indeed, as husbands with traditional attitudes continued to resist undertaking tasks which they perceived as 'women's work', the authors concluded that men may be unwilling to provide domestic support, even when their wives become physically disabled. However, it was unclear if men would be more willing to help with cooking when their wives become cognitively disabled. Accordingly, this is the first study to systematically explore whether men cook when their wives develop dementia.

### *The gender division in cooking*

Although the literature clearly demonstrates a gendered division in household tasks such as cleaning, the evidence is less clear-cut in relation to cooking, particularly as men are more willing to cook than to clean (see Kemmer *et al.* 1998). However, cooking has traditionally been a woman's responsibility and marital duty (Murcott 1983). Yet, although housework has been a key focus of research in this area, there has been less attention paid to the gender politics surrounding food and cooking, even though these aspects of domestic life can also highlight gendered patterns of 'power, control and autonomy' (Kemmer *et al.* 1998, p. 9). Although an ethnographic study of cooking habits among Scottish couples identified that women usually carried the responsibility for cooking, nonetheless, some couples shared this responsibility and a minority of men took on this role (Kemmer *et al.* 1998, Kemmer 2000). Similarly, half of the men in the research

by van Hooff (2011) did the bulk of the cooking. Hence, cooking ‘is no longer viewed as an exclusively feminine task’ such that more men cook for their partners (*ibid.*, p. 26). However, although men have the power to decide whether or not to cook (and those who choose to cook view it as a pleasurable activity) (*ibid.*), this task still tends to be a woman’s duty. Therefore, this study explored whether (older) men are willing (and able) to cook when their wives become cognitively disabled. Although previous research focused only on the social competence of people with dementia (as determined by their carers – for example, Byrne *et al.* 2000), this study explored the domestic competence of both spouses, particularly husbands who were carers.

### *The agency of women with dementia and everyday decision-making*

The agency exercised by people with dementia in their everyday lives is a neglected area of research, as the literature has been dominated by studies of the psychological impact of the condition on people with dementia and their carers, rather than sociological research (for example, Robinson *et al.* 2005, Cooper *et al.* 2008). In addition, hardly any consideration has been given to gendered experiences in dementia (see Bamford 2011). Although previous studies examined the challenge that dementia poses to maintaining couple relationships (for example, O’Shaughnessy *et al.* 2010), the authors did not consider whether gender inequality might continue to influence the agency that women with dementia exercise within their relationships, particularly in relation to the micro-aspects of their daily lives, such as domestic decision-making. Indeed, although research into couple relationships in dementia has frequently explored only the views of the carer-spouses, this study examined the perspectives of both spouses (for example, O’Shaughnessy *et al.* 2010, see also Braun *et al.* 2009).

The *Mental Capacity Act* (introduced in England and Wales in 2005) accords decision-making rights to adults who lack capacity (to make some decisions), thereby promoting their self-determination. Prior to this law, family members and professionals often made decisions on behalf of people with dementia without regard for their capacity, thereby depriving them of decisional autonomy (Collopy 1995, Boyle 2008). Indeed, previous research into decision-making in dementia only examined the views of family members (Hicks and Lam 1999, Adams 2006). Yet, exclusion from decision-making in dementia is a particular concern for women’s citizenship, as it is primarily women who develop dementia (67%), related to their longer life expectancy (Albanese *et al.* 2007). A study by Brittain *et al.* (2010) explored how the social model of disability might be used to promote the citizenship of people with dementia, but whether their experiences of citizenship might also be gendered was not considered. Indeed, as research into the lived experience of dementia tends to explain the domestic lives of couples solely in terms of the illness, the possible influence of gender dynamics (past and present) on roles and responsibilities is given little consideration (for example, Braun *et al.* 2009). Hence, there was a need for in-depth research into how people with dementia – especially women – exercise agency within couple relationships, notably through their involvement in everyday decision-making processes. Whilst the wider study examined a range of decisions, this paper focuses on the choice and control that women with dementia exercised over cooking.

### **Methods**

Ethnographic and creative methods were used (including participant observation and interviews) (see Mason and Davies 2009, Mason and Dale 2011). Each couple was

observed (on one day, for up to 3.5 h) going about their usual daily routines (including preparing meals) in order to observe decision-making in action. The fieldwork was undertaken over at least four home visits, in order to develop a fuller understanding of the couples' decision-making processes and the decisional abilities of people with dementia. The duration of the fieldwork with each couple (from obtaining consent to completion) varied from 2 to 21 weeks (lengthier periods occurred when couples' holidays intervened or due to a spouse's physical ill-health). In addition, a prior home visit and attendance at 'Wellbeing Cafes' (which some couples attended) were helpful in making the researchers familiar to the people with dementia at the outset, gaining their trust and enabling us to learn about each couple's routines and interests (see McKillop and Wilkinson 2004). The Cafes were regular, informal events held in community centres (run by statutory and voluntary organisations) which provided opportunities for social interaction and advice to people with dementia and their carers (see Miesen and Jones 2004). Individual interviews with each partner enabled their respective views to be explored and facilitated comparison with the 'joint' perspectives which couples presented during other fieldwork (see van Hooff 2011). The participant observation constituted a methodological advance on previous research into couples' domestic lives as this frequently enabled direct observation of their decision-making processes and their actual division of household labour. Ethical approval was obtained from the Social Care Research Ethics Committee in England. A person-centred approach was used to informally assess the capacity of people with dementia to decide to take part in the research (see Mayo and Wallhagen 2009), and their consent was also verified throughout the study (that is, there was process consent) (Dewing 2007). Although semi-structured interviews were undertaken with both partners where possible, the interview process for each person with dementia was adapted to her/his cognitive and communication skills. For example, unstructured, conversational interviews were used which incorporated closed questions or topics on key themes of interest (such as their likes and dislikes), in order to explore their agreement or disagreement (see Acton *et al.* 2007). Where the people with dementia had speech difficulties, their non-verbal communication was noted (such as tone of voice, facial expressions and gestures) (see Kontos 2004). Photographs of the couples (including during observations) were used as visual and memory aids during the ongoing fieldwork, in order to develop continuity, prompt recall and elicit conversation (see Harper 2002). An 'interaction' method was devised to facilitate one woman's communication and engagement when it was not possible to readily interview her (see Grove *et al.* 1999). More specifically, the author spent time with her on a one-to-one basis; used talk and sensory aids (such as a soft toy and musical instruments) to stimulate her communication and engagement; listened attentively to her monologue and observed her non-verbal expressions.

### **Recruitment**

The research was undertaken in a large, metropolitan local authority area in the North of England. Couples were recruited via Wellbeing Cafes for people with dementia (and other disabled people), support groups and day centres run by voluntary and statutory organisations. Staff in the local Alzheimer's Society wrote to couples on our behalf (including those who did not support services) and the study was also advertised in their newsletter. Co-ordinators from the Wellbeing Cafes permitted the researchers to talk briefly at the Cafes in order to promote the study. In addition, managers of community organisations and day centres and church workers provided study information to people with dementia and carers.

Theoretical sampling (Mason 1996) was used to recruit women and men with dementia in order to explore their gendered experiences and to ensure variation in the couples' social class and ethnicity (for example, by recruiting participants via social cafes aimed at specific ethnic groups). The couples were eligible to participate if they were co-resident; one partner had been diagnosed with dementia and both partners were willing to take part. Couples were excluded where the partner with dementia had only recently been diagnosed (within the previous 6 months), to allow time for adjustment. The combined terms of memory problems and dementia were used to allow participants to determine their preferred terminology, on the basis that some people may not have accepted the diagnosis (see Langdon *et al.* 2007). Although research often focuses on people with early-stage dementia who tend to have better cognitive and verbal skills (for example, Harman and Clare 2006), to promote inclusion, the use of flexible and creative methods enabled people with significantly impaired speech and/or more advanced dementia to participate. Both partners were asked to complete written consent forms (where feasible). Where the people with dementia did not have the capacity to consent, their spouses were consulted as to whether they would have wanted to participate and if they were happy for them to take part (as per the *Mental Capacity Act*). The fieldwork was undertaken between June 2010 and May 2011. The interviews were digitally recorded and transcribed verbatim; fieldwork notes were recorded throughout.

### *Data analysis*

Thematic data analysis was undertaken manually (see Basit 2003). For the first level of coding, the key themes in each couple's data were identified in order to explore the couple's perspective, but also to enable the views and experiences of the respective partners to be discerned. The analysis was partly informed by theoretical concepts but was also open-ended to allow new concepts to emerge. The types of decisions the couples made on a daily basis were identified (such as who was going to cook) and the related decisional processes were examined in detail. The couples' previous and current decision-making styles were compared (that is, the approaches used before and after the onset of dementia). The carer-spouses' perceptions of their partners' decisional and practical abilities; their rationales and motivations for including or excluding them from decisions about cooking and the degree of control which women with dementia exerted over this issue were explored. The support given by the carer-spouses (both decision-making support and any practical assistance) and its effects on the decisional (and executional) capacity of people with dementia were examined (see Collopy 1995). In addition, the cooking responsibilities and expertise of both spouses (pre- and post-dementia) were considered. An interpretative approach was used at times to discern meaning in the data from people with dementia (particularly their non-verbal expressions) (see Grove *et al.* 1999). To ensure the validity of interpretations, these were often checked at the time of the fieldwork (for example, by rephrasing a statement to clarify understanding). In addition, during the data analysis phase, the various sources and types of evidence (including speech and non-verbal data) were corroborated in order to verify the accuracy of interpretations.

For the second level of coding, comparative analysis of the data from all the couples was undertaken to identify whether the decisions about cooking and the related decision-making processes were influenced by social factors (notably gender). The data were initially analysed by two researchers (in order to achieve a consensus on interpretation and ensure validity) and the summary analysis for all the couples was discussed by the research team. To ensure the participants' interpretations informed our analysis, they were given



the opportunity to clarify key issues, although this was not feasible for all the people with dementia.

### *Sample characteristics*

Twenty-one married couples took part in the research. The sample consisted of 12 women and 9 men with dementia and their spouses (some had early-stage dementia; for others, it was more advanced). The duration since diagnosis varied from 1 to 12 years. Although the term ‘carer-spouses’ is used throughout to distinguish them from their partners with dementia, it should be noted that they did not necessarily identify themselves as ‘carers’. Whilst the age groups of the participants ranged from 1940s to 1980s, it was primarily an older sample (over 65 years). A quarter of the people with dementia lacked the capacity to consent to taking part in the research (5 out of 21 – four were women). Two-thirds of the couples occupied ‘higher’ social-class positions (I, II and III Non-Manual), whereas one-third were in ‘lower’ class positions (III Manual, IV and V). The sample was predominantly White British, but also included one South Asian couple (the precise ethnic group is anonymised). Although the research aimed to ensure a more ethnically diverse sample, this was unsuccessful though broader samples would be integral to policy recommendations in the future.

### **The division of labour in couples living with dementia**

#### *Wives cook for their husbands with dementia*

Cooking was of little concern or necessity to any of the men with dementia, as this had primarily been their wives’ role and responsibility throughout the marriage. Accordingly, Joanne<sup>1</sup> (a wife-carer) described what had essentially been a gendered division of roles in her earlier marriage (and had remained as such):

And I guess in terms of being a home-maker um, it was, made more sense for me to be at home when the children were young and - - - (her husband) was the finance man so he managed the money part.

Similarly, Gillian (another wife-carer) said she had always done the cooking: ‘Well, cooking – I’ve always seen to that and I’ve always, you know, said what we want for groceries and everything like that’. Likewise, the men with dementia explained that they did not have any responsibility for cooking as this was their wives’ domain. For example, Gordon was quite clear that ‘I have nothing to do with the domestic arrangements’, as his wife had always done the cooking. In turn, men with dementia admitted that they had no real cooking ability because they had never learned to cook. For example, Sid said: ‘I’m alright with the bacon sandwiches, but that’s about it.’ Similarly, previous research showed that older women usually retain the responsibility for cooking even after they retire (Sidenvall *et al.* 2000).

Nevertheless, some men with dementia were keen to emphasise that they helped their wives with basic food preparation. For example, although Paul said his wife did the cooking, he also commented that he usually peeled the potatoes for dinner: ‘I peel potatoes though, you know? [...] Bits of things like that, yes, but she more or less does it, yeah’. Yet, as the wife-carers had always done the cooking throughout the marriage and the kitchen was their established territory, they were not always keen when their husbands offered to help them in the kitchen. Although two wives perceived that their husbands lacked the ability to help with food preparation due to their dementia (but also because of



their historical lack of cooking expertise), as it was evident that these men actually retained some practical ability here (irrespective of their cognitive disability), their wives' attitudes probably contributed to 'excess disability' in these particular men (Brody 1971). For example, Gillian (a wife-carer) acknowledged that when her husband asked if he could help her in the kitchen, she usually declined his assistance:

But I mean he would come and say 'anything I can do?' I mean he'd come in the kitchen and the peelings, I have a, always have a bag to put me peelings in and things like that. 'Can I do anything?' and I say, 'well, I've done it now, thank you', you know.

Yet, this resulted in a lack of opportunities for him to undertake such tasks on a regular basis and maintain his basic domestic skills, thereby leading to 'excess disability'.

Although most of the men with dementia in this subgroup readily acknowledged that their wives did the cooking, in contrast, Mr Pasha (an Asian man) was reluctant to acknowledge that his wife was in charge of this task. More specifically, he said he helped his wife to cook or alternatively that he cooked himself (as he had previously worked in the catering industry) because he felt she had lost interest (due to her own health problems). He said: 'She does cooking and then I help her as well' but also said 'er, she used to cook, right? She's not interested in it now, er, I don't know'. Yet, his wife said (speaking mainly in Urdu through a community worker/interpreter) that she had always been responsible for the cooking:

I talk to my husband, I say '--- (name), what do you want today? You like shall I make for you?' [...] After he said 'today make rice, make chicken', or his order for me. After (that) I go buy the food and I start cooking.

The same wife-carer had taken the lead in the couple's overall decision-making after her husband developed dementia because he had difficulty in making decisions. Indeed, the decision-making had similarly shifted to a 'carer-dominated' style in the majority of the couples following the onset of dementia. More specifically, when the carer-spouse currently made most or all of the decisions for the couple or else took the lead in this decision-making, the couple's decision-making style was defined as carer-dominated (see Hirschman *et al.* 2004). However, as this particular man had dominated the couple's decision-making before he developed dementia, it appeared that he was unwilling to relinquish his historical control, as he frequently resisted when his wife tried to make decisions on their behalf. Thus, his reluctance to acknowledge that his wife was in charge of the cooking appeared to be one area where he tried to demonstrate his continued authority and control within the marriage. Indeed, the overall study (into decision-making more generally) showed that men more readily dominated the couples' decision-making, whether before or after their partners developed dementia.

### ***When husband-carers 'can't cook' or 'won't cook'***

For women with dementia who had always done the cooking in the marriage, but who had difficulty with this task now or could no longer cook, their husbands were not always willing or able to take over this duty from their wives (6 out of 21 cases). These women often acknowledged that they found cooking somewhat of a challenge now. For example, Dorothy said she found cooking difficult, but she could still do basic tasks like peeling vegetables. She said

well I, I haven't been, I can't concentrate, I find cooking much harder than I used to do, so for meals and things [...] and, uh, (husband's name), I think (husband) was, he wouldn't normally do, you know, cooking and but, uh, he did that the other day, (I) thought that was

very nice of him [...] well, I did potatoes, I peel the potatoes and that kind of thing and, uh, yes we had a nice meal together, it was rather nice for a change.

In contrast, however, a couple of women were reluctant to admit that they could no longer cook. For example, Mary initially said she did the cooking – ‘I do’ – but then said the couple did the cooking together – ‘we join’ – and finally said she told her husband ‘what to do and he does it without any bother’. As one of these women had relatively more impaired decisional capacity and reduced ability to undertake activities of daily living, it may be that she did not want to acknowledge the extent of the impact of the dementia on her everyday skills. In addition, since cooking expertise is integral to traditional notions of femininity and the role of a wife, these women with dementia may have been reticent to acknowledge their loss of domestic competency because of the possible implications for their status as wives.

Although women with dementia could often have managed to cook if they had received some assistance from their husbands, the latter were frequently reluctant to help, particularly if they lacked cooking expertise. Consequently, husband-carers who could not, or would not, cook found alternative means of providing meals for the couples. More specifically, they bought ready-made or take-away meals or ate in pubs or cafes or, alternatively, went to a daughter’s house for occasional meals. For example, Steve said he had to help a lot more with household tasks – particularly cooking – after his wife developed dementia: ‘yes, I have to do a lot more than I ever had to do [...] things like, helping prepare meals’. However, rather than actually cooking, instead he heated ready-made meals in the microwave: ‘for supper, supper we tend to live on M & S meals, they go in the microwave, not in the oven’. Similarly, John (a husband-carer) said the couple often ate ready meals now because his wife found cooking challenging and he could not help as he had never learned to cook:

we’ve almost, for example, given up meat because that involves her doing cooking preparation. (We) used to have more meat dishes which, uh, is slightly more tricky. Now it tends to be ready meals or things that are very easy to, uh, to just shove in the hot oven and take out after a certain time and even then I have to make sure that I’m there when the time comes to take them out. Um, because she can forget what’s in the oven, or indeed that she’s put anything in the oven.

At times, these husbands discouraged or stopped their wives from cooking if they perceived that they no longer cooked to an adequate standard (for example, if food got burnt when their wives forget about it). However, whilst such husbands were somewhat critical of their wives’ loss of domestic expertise and prevented them from cooking rather than helping them with a task which they often enjoyed, they did not acknowledge the social incompetency inherent in their own lack of cooking proficiency. For example, Anthony (a husband-carer) said:

No. Oh, no, I wouldn’t trust her really, you know, ‘cos, er, the thing is she’ll put something on and, er, you know, in the pan or something and the next thing ‘ooh, what’s burning like?’, and it’s there in the pan. You know, we’ve had to get two or three new pans because of, well, I just threw them away (he laughed). But it’s so dangerous now like, but she used to do all the cooking and make dinners, you know, a full Sunday dinner. You know, Yorkshire puddings and beef and gravy, and, er, peas and potatoes and that – every weekend. But I’m not a cook like.

In addition, these husband-carers complained that their wives had lost the initiative for cooking and the ability to concentrate, attributing these perceived changes to their condition. Indeed, a lack of motivation is defined as symptomatic of dementia (for example, World Health Organisation 1993). On the contrary, however, a few women with

dementia said they had lost interest in cooking because they viewed it as a tiresome chore, which demonstrated a subtle expression of agency whereby they sought to absolve themselves of this domestic responsibility (albeit only when their dementia provided a justification). Indeed, Jenny quite readily said ‘I don’t enjoy it like I used to do’ and found it ‘a bind’ and ‘hard work’ and that it had always irritated her that her husband ‘can’t cook, won’t cook’.

### *Some husbands cook for their wives with dementia*

A few husband-carers took over the cooking when their wives with dementia were no longer able to cook (4 out of 21). Although these men had usually done some of the cooking earlier in their marriages, nevertheless, they still found cooking difficult, particularly if they lacked basic familiarity with a cooker. Although Malcolm had taken on a lot of the cooking several years previously (when he had to give up work due to ill-health), he was only able to use the cooker rings and microwave and did not know how to use the grill or oven. As a result, the couple often ate ready meals or went out for a pub lunch instead. He said:

Yeah. Um, cooking on the cooker. Now I’ve never, I’ve not used the cooker yet, I’m frightened to death of it (he laughed). I do all the, I do all the top rings. I can do all those [...] I’ve not tried the grill and I’ve not tried the oven yet. So that’s something that I will have to get rid of but, then again, I’ve got this [...] I’ve got a microwave.

### *When husband-carers exclude their wives from cooking*

There was conflict within two couples over whether the wives with dementia should continue to be involved in cooking. In both cases, even though the women with dementia enjoyed cooking and retained their cooking ability, their husbands had taken over this task and actively resisted their wives’ involvement. As these husbands currently dominated the overall decision-making in the couples (that is, ‘carer-dominated’ decision-making), it appeared that cooking was one of the domains where they also wanted to exercise control, particularly as they themselves found this domestic activity enjoyable (see van Hooff 2011). Both husbands attributed their wives’ exclusion from the kitchen to their dementia, complaining either about their perceived slowness or the inadequacy of their cooking. William said:

See she made our tea for us [...], but it took a lot longer than it would have done if it had been me. Uh, so yeah, I let her do things occasionally in the kitchen but the reason I don’t let her do more, or don’t ask her to do more, is because she takes so long over stuff.

A reason for the women’s exclusion was offered by Henry and the explanation seemed to reflect a desire for control. He said:

And she’s got a thing of trying some of these junk foods as I call them. I don’t like junk food. I like to cook my food. I don’t want it warmed up in a little packet that came from I don’t know where. Not interested [...] (When his wife tried to suggest) ‘we’ll try this’ (he then said) ‘no, I don’t want that’ (whereupon she said) ‘but I bought it for us for dinner time’, (but he insisted) ‘no, I don’t like that’. And she’s forgotten that for all our married life, I’ve tried it once and said I don’t like it and I don’t want to try it again [...] And she’s forgotten all that of course.

Indeed, even when William did not want to cook, he organised for the couple to go out for lunch, rather than giving his wife the opportunity to undertake an activity she enjoyed. As his wife said ‘yes, it saves ---- (husband’s name) having to cook (she laughed) [...], he won’t let me cook’.

However, the same women with dementia were reluctant to acknowledge that their husbands had taken over the cooking, as they both initially said they did the cooking on their own or helped their husbands with this task, but then acknowledged that their husbands would not let them cook. Carol said: 'Uh, he does all the cooking, he won't let me do the cooking, although I like cooking as well'. Moreover, although these men prevented their wives from cooking (attributing this to their dementia), they nonetheless expected them to do all the cleaning. As Carol went on to point out (with apparent resentment, although she masked this with humour): 'he won't do cleaning up, I do all the cleaning up (she laughed)'. Yet, even though these women were unhappy about their domestic exclusion, they were unwilling to challenge their husbands directly and, instead, expressed their resistance more subtly via their behaviour. More specifically, they tried to enter the kitchen and join in whenever their husbands started cooking. Carol said: 'he takes all of the cooking and etceteras over so (she laughed)' and when asked how she felt about this she said: 'well, I like doing it as well, you know [...] it's a, in fact, in a sense, when he starts doing it I go in the kitchen and join in'. Indeed, Henry complained about his wife's ongoing attempts to involve herself in the cooking: 'ah, but now she's moving back into the kitchen again'. However, rather than criticising their husbands' lack of support and the control they sought here, the two women attributed their reduced involvement to their poor health (one attributing this to the dementia and the other to a physical health problem). Specifically, Carol opted to stay silent, rather than discuss the issue of cooking with her husband (again, masking her unhappiness with humour): 'uh, I like cooking as well but uh, I keep my mouth shut (she laughed)'. In addition, she also blamed herself: 'I'm in an awkward way, I'm feeling awkward (again she laughed)'.

### **Cooking duties and gender inequality in dementia**

#### ***Most men 'can't cook' or 'won't cook'***

Previous research had shown that there is less of a gender divide in cooking than in other areas of housework (for example, van Hooff 2011) and, similarly, our study identified that a few of the (older) men had helped with cooking even when the couples were younger. However, although a minority of the husband-carers currently cooked out of necessity, most of them either avoided this task or took it over unnecessarily when their wives with dementia were still able, and wished, to continue cooking. Although men with dementia continue to be catered for by their wives, women with dementia who can no longer cook for themselves often cannot rely on their husbands to cater for them or, conversely, see their husbands taking over and excluding them. Of course, cooking was usually a woman's established marital duty such that this gender differentiation in household roles was habituated in the couples (see Speakman and Marchington 1999). Allen and Webster (2001) had identified that gender inequity in housework (including cooking) also applies in couples where women are physically disabled (but to a lesser degree) and it is similarly evident (in the main) when women are cognitively disabled.

The research had also identified that husband-carers were unwilling to take over housework (notably cleaning) unless the severity of their wives' dementia rendered this absolutely necessary. Yet, although husband-carers were frequently unwilling (or unable) to take over cooking, others actively *chose* this domestic activity because they found it pleasurable. Accordingly, husband-carers expected their wives with dementia to perform a task disliked by both sexes (cleaning), but prevented them from undertaking a more pleasurable task (cooking) (see also van Hooff 2011). Thus, men continue to view housework as a 'woman's job' (Baxter 2000), whereas cooking is less feminised (van

Hooff 2011). Men have the power to decide what household tasks they will perform in order to minimise their labour and maximise their enjoyment (see also van Hooff 2011). Husbands exercised choice and control over whether they cooked and often exercised control over whether their wives cooked, thereby depriving them of decisional autonomy. Husbands' domination of the couples' decision-making was at times a continuation of the authority or control which they had established earlier in the marriages. For example, Dennis acknowledged that he had been domineering throughout the couple's marriage: 'But I think the decisions we made, I made a lot of them, um, in, um, and I could be quite domineering.' Women who needed help with cooking had little choice over whether to continue (when assistance was not forthcoming from their husbands) and women who were readily able (but were prevented by their husbands) had no choice or control over this matter. Thus, men often maintained their 'male privilege' (McMahon 1999).

### *Managing meals without cooking*

Although the ownership of housework in marriage (including cooking) ordinarily rests with wives (Speakman and Marchington 1999), a shift in this ownership occurs when women develop dementia, as their husbands take over the responsibility for *managing* meals when their wives can no longer manage alone. Although women caring for men with dementia continued to carry responsibility for managing *and* performing cooking, husband-carers in the main only managed cooking. Previous research had identified that men feign technical ignorance (about household appliances) and incompetency in order to avoid doing housework (for example, Speakman and Marchington 1999) and, likewise, most of the men in our study (whether they had dementia or were carers) used similar strategies to avoid cooking, including exercising a presumed male right whereby they had never learned to cook.

Although wife-carers continued to provide men with dementia with home-cooked meals, husband-carers found alternative means of supplying dinners, including buying ready-made or take-away food or organising meals outside the home (whether purchased or provided by a daughter). Similarly, previous research had identified that single men (who do not have female partners to cook for them) avoid this task by eating ready-made or convenience foods, and husbands of physically disabled women resort to utilising family to evade housework (Kemmer *et al.* 1998, Kemmer 2000, Allen and Webster 2001).

### *Competency and capacity*

Whilst some husband-carers were critical of their wives' perceived loss of domestic skills (attributed to the dementia), they did not acknowledge the social incompetency inherent in their own lack of cooking expertise. A decline or loss of cooking ability was an area where the impact of dementia was quite salient relatively early in the condition, making this a particular concern for women. As a minority of the women with dementia were reluctant to admit that they could no longer cook, their reticence may have reflected a degree of vulnerability about their (social) competency as wives. Yet, since other women with dementia were deterred or even prevented from cooking when they still retained this ability (albeit some needed practical support), a change in a wife's cooking role was not always due to her dementia but was also due to a lack of domestic support and gendered authority or control exercised by her husband. More specifically, women who lacked the executional capacity (but retained the necessary decisional capacity), did not receive the

necessary practical assistance from their husbands to enable them to overcome their disability and were also deprived of the opportunity to decide whether to continue cooking. In addition, women with dementia who could still cook were constrained by their husbands from using their extant decisional *and* executorial capacity (see Collopy 1995). Yet, it should be noted that ‘assisted autonomy’ is necessary to promote the agency of people with dementia (Boyle 2008). Although Sabat (2003, p. 85) had suggested that people with dementia are susceptible to ‘malignant positioning’ by others which can undermine their sense of social competency, it is important to note that, at times, this negative positioning may be explained more by gender inequality than by – what Ward *et al.* (2008) referred to as – ‘cognitive disablism’.

Although some husband-carers criticised their wives’ perceived loss of cooking ability, in contrast, women with dementia who had been deterred or excluded from cooking were reluctant to overtly criticise their husbands’ lack of domestic support (or competency) or to directly challenge their exclusion (often blaming themselves instead). Although the women’s reticence probably reflected a habituated pattern of gendered relations within couples (see also Brannen and Moss 1987), it may also have suggested a heightened sense of the vulnerability of their position as wives (given their dementia). Nonetheless, women with dementia who had been excluded from cooking used embodied (rather than discursive) agency to convey their views and feelings, by boldly entering what had essentially become their husbands’ domestic territory and involving themselves nonetheless (see Giddens 1984, Shilling 1999). Yet, overall, as husband-carers exercised authority (or even control) over the management of cooking, women with dementia often had little say in whether to continue with this task and even when they clearly wished (and were readily able) to cook, their decisional capacity (and autonomy) was not always respected. However, as this was a small-scale study, the findings may not be generalisable to other couples with dementia.

## Conclusions

Given that the prevailing gender ideology requires that women take care of men (McMahon 1999), most (older) husbands are unable and/or unwilling to provide *domestic* care for their wives when they develop dementia. As there is little consideration given to the significance of gender in dementia care policy (for example, the *Mental Capacity Act* and the National Dementia Strategy – Department of Health 2009), such policy needs to be much more gendered in order to promote the equality of women with dementia. In turn, there is a need for health and social care professionals to consider the gendered constraints that women with dementia may experience and to encourage male carers to provide domestic support. Indeed, as they often lack cooking expertise, this may be an area where carer organisations can provide advice or training.

Since research into living with dementia tends to disregard gender (and gender debate often neglects disability), previous research has overlooked the potential impact of gender inequality on the agency of women with dementia. Yet, this study has demonstrated that gender inequality persists even when women become cognitively disabled, and that it can pose as much (or even more of) a challenge to their agency than their disability. Whilst the competency of people with dementia is subject to investigation by health and social care providers, the *domestic* competency of women with dementia is also subject to scrutiny by their husbands. Accordingly, a critical gender perspective is needed in future research which shifts the focus from women’s capacity and competency (whilst recognising their extant capabilities) to an analysis of interdependency which takes into account the



authority and domestic competency of male carers. At the same time, however, some women with dementia were quite creative in how they expressed their gendered agency within their marriages (see Davis 1991), including exhibiting a lack of interest in cooking in order to absolve themselves of their traditional duty as wives. Whilst people with dementia have traditionally been assumed to lack agency, the research showed how women with dementia convey a 'sense of agency' within their relationships, albeit constrained by gendered norms and expectations (see Kabeer 1999). Thus, this study has highlighted the need for a multidimensional approach to researching everyday life in dementia which takes account of intersectionality, in order to develop a more enriched understanding of the social factors that facilitate or constrain women's agency (see Walby 2007). The study also demonstrated the value of facilitating the research participation of people with significantly impaired speech and/or more advanced dementia. However, as there was limited representation from minority ethnic groups, future research should explore how (and to what extent) women with dementia from diverse ethnic groups make decisions about their domestic lives.

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### Note

1. Pseudonyms are used throughout.

### Notes on contributor

Geraldine Boyle is a Lecturer in the Centre for Applied Social Research, University of Bradford. With a background in social policy, her research interests focus on the personal lives of people with dementia; social and health inequalities and social care and human rights. In addition to leading the current research, she was involved in a national study into best interests decisions made by health and social care professionals on behalf of people lacking capacity.

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